Summary of Benefits

This section summarizes your UMP Neighborhood benefits.

Please note that UMP Neighborhood has no waiting period for coverage of preexisting conditions.

UMP Neighborhood covers only medically necessary services and supplies, as defined on pages 75-76. Please refer to "Covered Expenses" as well as "Expenses Not Covered, Exclusions, and Limitations" for more details.

The fact that a provider orders a test or prescribes a treatment does not necessarily mean that it is covered by UMP Neighborhood. Please consult this Certificate of Coverage*, or call UMP Neighborhood Customer Service if you have questions about whether a service or supply is covered.*

For any UMP Neighborhood covered benefit, once you have met the cost-sharing requirements, UMP Neighborhood pays at the levels shown on the following summary charts, subject to any benefit maximums or limits indicated. The percentage paid by UMP Neighborhood refers to percentage of the allowed charge only. The remaining amount of the allowed charge is your enrollee coinsurance (defined on page 74).

Only the allowed charge is covered—the maximum payment UMP Neighborhood allows for a specific service or supply (see definition on page 72). In many cases, UMP Neighborhood's allowed charge is less than the provider's billed charge for the service. This means that for most non-network and out-of-network services, you will be responsible for not only the enrollee coinsurance but also the difference between the billed and allowed charges.

For an explanation of network, non-network, and out-of-network reimbursement, see "Your Medical/Surgical Provider Options" on pages 13-14.

In most circumstances, UMP Neighborhood follows Medicare coverage guidelines, payment policies, and billing requirements.

Some services also have specific limits, as shown in the summary charts.

The following sections describe your UMP Neighborhood benefits along with other details you'll need to use your coverage effectively. If you have questions, see the Directory (inside the front cover) for contact information.

Services received outside of Washington State that are not for treatment of urgent conditions or medical emergencies are not covered.

For more information on what isn't covered and benefit limits, see "Summary of Benefits" and "Expenses Not Covered, Exclusions, and Limitations."

Summary of Benefits

Percentages shown in chart apply to the UMP Neighborhood allowed charge, which is the amount agreed upon by network providers.

Benefits	Plan payment for network providers	Plan payment for non-network providers*	Preauthorization required?	See page**
Acupuncture 16 treatments max/year	90%	60%	No	23, 42
Ambulance				23, 42
Air and ground	80%	80%	No	
Biofeedback (if for mental health diagnosis: See Mental Health benefits)	90%	60%	No	24, 29
Blood and Blood Derivatives	90%	60%	No, except stem cell harvesting for transplant purposes	24
Bone, Eye, and Skin Bank Services	90%	60%	No	24
Cardiac and Pulmonary Rehabilitation	90%	60%	Yes	18, 24
Chemical Dependency Treatment $13,000 maximum plan payment per consecutive 24 calendar month period for inpatient and outpatient treatment combined ($13,000 limit excludes detox if you haven't been admitted to a chemical dependency program when receiving those services)				24, 42, 73
• **Inpatient**	100% after $200 copay/day; $600 max copay/person/year	60%	No	
• **Outpatient**	90%	60%	No	
Diabetes Education See page 25.	90%	60%	No	25, 42, 43
Diagnostic Test, Laboratory, and X-Rays (outpatient)	90%	60%	Certain services	25, 44
Dialysis	90%	60%	No	26

(continued on next page)

* Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network services on page 14.

** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

Summary of Benefits, continued

Percentages shown in chart apply to the UMP Neighborhood allowed charge, which is the amount agreed upon by network providers.

Benefits	Plan payment for network providers	Plan payment for non-network providers*	Preauthorization required?	See page**
Durable Medical Equipment, Supplies, and Prostheses ***Note:*** For a wig or hairpiece to replace hair lost due to radiation or chemotherapy, $100 lifetime max	90%	60%	Yes, for rentals over 3 months and purchases over $1,000	26, 43, 74
Emergency Room (ER) ER copay waived if admitted directly from ER; copay does not count toward the medical/surgical out-of-pocket limit.	90% after $75* copay/visit	80% after $75* copay/visit	No	26-27, 75
Hearing Care $400 max/36 months applies to routine hearing exam, hearing aid, and rental/repair combined	90%	60%	No	27, 43
Home Health Care	90%	60%	Yes	18, 27, 43, 75
Hospice Care Six months maximum benefit				18, 27, 43, 75
• **Inpatient**				
When preauthorized	100%	60%	Yes	
When NOT preauthorized	90%	60%	No	
• **Respite care** ($5,000 lifetime max)	100%	60%	Yes	
Hospital Services				
• **Inpatient**				28, 44
Facility services *May not include doctors' and other professional services*	100% after $200 copay/day; $600 max copay/person/year	60%	No; see "Physical, Occupational, and Speech Therapy" for exceptions.	
Professional services *See page 28 for important information*	90%	60%	No	
• **Outpatient**	90%	60%	No	28
Mammograms				
• **Screening mammograms** (beginning at age 40, every one or two years)	100%	60%	No	25, 39
• **Diagnostic mammograms**	90%	60%	No	25

* Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network services on page 14.

** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

Percentages shown in chart apply to the UMP Neighborhood allowed charge, which is the amount agreed upon by network providers.

Benefits	Plan payment for network providers	Plan payment for non-network providers*	Preauthorization required?	See page**
Massage Therapy 16 visits/max	90%	Not applicable; **massage therapists must be network providers to be covered**.	Only for services exceeding one hour per session. Treatment plan required.	18, 28, 44
Mastectomy and Related Services	90%	60%	No	28
Mental Health Treatment				18, 29, 44, 45
• **Inpatient:** 10 days max/year	100% after $200 copay/day; $600 max copay/person/year	60%	No, except for partial hospitalization services	
• **Outpatient:** 20 visits max/year	90%	60%	No	
Naturopathic Physician Services	90%	60%	No	29, 42, 43
Neurodevelopmental Therapy (Ages 6 years and under)				30, 44
• **Inpatient:** 60 days max/year	100% after $200 copay/day; $600 max copay/person/year	60%	No	
• **Outpatient:** 60 visits max/year for all therapies combined	90%	60%	No, but treatment plan required	
Obstetric and Newborn Care				30
• **Inpatient**				
Facility charges	100% after $200 copay/day; $600 max copay/person/year (Routine newborn nursery care is not subject to copay.)	60%	No	
Professional services	90%	60%	No	
• **Outpatient**	90%	60%	No	
Office, Clinic, and Hospital Visits	90%	60%	No	30, 42, 44

(continued on next page)

* Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network services on page 14.

** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

Summary of Benefits, continued

Percentages shown in chart apply to the UMP Neighborhood allowed charge, which is the amount agreed upon by network providers.

Benefits	Plan payment for network providers	Plan payment for non-network providers*	Preauthorization required?	See page**
Organ Transplants				18, 31, 44
• **Inpatient**				
Facility charges	100% after $200 copay/day; $600 max copay/person/year	60%	Yes	
Professional services	90%	60%	Yes	
• **Outpatient**				
Donor search (bone marrow, stem cell, umbilical cord) is limited to 15 searches per transplant	90%	60%	Yes	
Out-of-Network Services See page 77 for definition.	Not applicable	80%	Varies by service/supply	14, 77
Outpatient/Day Surgery, Ambulatory Surgical Center (ASC)	90%	60%	No	31, 45
Phenylkentonuria (PKU) Supplements	90%	60%	No	31
Physical, Occupational, and Speech Therapy				18, 31-32
• **Inpatient:** 60 days max/year for all therapies combined	100% after $200 copay/day; $600 max copay/person/year	60%	Yes	
• **Outpatient:** 60 visits max/year for all therapies combined	90%	60%	No, but treatment plan required	

* Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network services on page 14.

** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

Percentages shown in chart apply to the UMP Neighborhood allowed charge, which is the amount agreed upon by network providers.

Benefits	Plan payment for network providers	Plan payment for non-network providers*	Preauthorization required?	See page**
Prescription Drugs (up to a 90-day supply for most drugs)				19-22, 32-34, 42, 43, 44, 45
• **Retail pharmacies*:** Annual prescription drug deductible applies. After you meet your annual prescription drug deductible, your cost-share limit for Tier 1 and Tier 2 drugs is: $75 per prescription for up to 30 days' supply, $150 per prescription for 31-60 days' supply, and $225 per prescription for 61-90 days' supply. Limit does not apply to Tier 3 drugs and prescription drug claims submitted by the enrollee.				
Tier 1: Generic drugs, all insulin, all disposable diabetic supplies, and certain specialty drugs	90% (enrollee coinsurance is 10% or cost-share limit, whichever is less)	90%	Certain drugs	
Tier 2: Preferred brand-name drugs	70% (enrollee coinsurance is 30% or cost-share limit, whichever is less)	70%	Certain drugs	
Tier 3: Nonpreferred brand-name drugs and compounded drugs	50%	50%	Certain drugs	
• **Mail-service pharmacy*:** Annual prescription drug deductible applies. If the actual price of the medication is less than the standard copay, you pay a minimum charge of $8.99 or the cost of the drug, whichever is greater—but not more than the standard copay.				
Tier 1: Generic drugs, all insulin, all disposable diabetic supplies, and certain specialty drugs	100% after $10 copay/refill	See note below	Certain drugs	
Tier 2: Preferred brand-name drugs	100% after $40 copay/refill	See note below	Certain drugs	
Tier 3: Nonpreferred brand-name drugs and compounded drugs	100% after $100 copay/refill	See note below	Certain drugs	

***Please note:** If you purchase prescription drugs from a mail-order or Internet pharmacy other than Express Scripts and submit claims yourself, prescription drug benefits will be paid as for a non-network retail pharmacy (see pages 19-21).*

(continued on next page)

* Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network services on page 14.

** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

Percentages shown in chart apply to the UMP Neighborhood allowed charge, which is the amount agreed upon by network providers.

Benefits	Plan payment for network providers	Plan payment for non-network providers*	Preauthorization required?	See page**
Preventive Care Only certain services are covered as preventive care. See list of covered services on pages 35-39.	100%	60%	No	34-39, 42
Radiation and Chemotherapy	90%	60%	No	40
Second Opinions				18, 40
• **When required by UMP**	100%	100%	No	
• **When optional**	90%	90%	No	
Skilled Nursing Facility 150 days max/year	100% after $200 copay/day; $600 max copay/person/year	60%	Yes	18, 40, 44, 45
Spinal and Extremity Manipulations 10 visits max/year	90%	60%	No	40, 44
Temporomandibular Joint (TMJ) Treatment (surgical)	90%	60%	Yes	18, 41
Tobacco Cessation Program *Free & Clear* program only	100%	Not covered	No	32, 41, 45
Vision Care				41, 44, 45
• **Eye exams** (routine) Once per calendar year	90%	60%	No	
• **Vision hardware** Including frames, lenses, contact lenses, and fitting fees combined	$100 max plan payment every two calendar years	$100 max plan payment every two calendar years	No	
Well-Baby Preventive Care Services See specific services covered under "Preventive Care"	100%	60%	No	34-37, 42

* Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network services on page 14.

** Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.